College of REGISTERED PSYCHIATRIC NURSES of Alberta

REQUEST FOR SPECIAL TESTING ACCOMMODATIONS
RPNC EXAMINATION

Documentation of Disability Related Needs Form

Complete this form if you have a disability that requires accommodation in taking the RPNC examination.

SECTION A – CANDIDATE ONLY

Complete Section A **ONLY** and forward it to the **Qualified Health Professional**

First/Given Name	Last/Family Name	Application Number

Other Surname(s)(your last/family name at birth, your maiden name or other former names):	Date of Birth

Mailing Address

I give my consent to the health professional completing Section B to release information regarding my condition along with rational for this recommendation and send it directly to the College of Registered Psychiatric Nurses of Alberta (CRPNA).

_____ _____

Date Hint: Use 'Fill & Sign' feature Then select ' Add Signature' from menu

SECTION B – TO BE COMPLETED BY A QUALIFIED HEALTH PROFESSIONAL

Please provide the following information concerning the above candidate and return this form directly to CRPNA via email at crpna@crpna.ab.ca.

NOTE: THIS IS NOT TO BE SENT BY THE CANDIDATE

I have known _____ since _____ in my capacity
(name of candidate) (mm/dd/yy)

as a _____. Due to the nature of the candidate's disability
(professional title)

_____, it is in my opinion that the
(description of disability)

candidate should be accommodated with the following (check all that apply):

☐ Separate room ☐ Adjustable contrast ☐ Adjustable font size ☐ Reader

☐ Recorder ☐ Screen magnifier

☐ Other (specify) _____

Additional time (please select one): ◯ Time and a half ◯ Double time ◯ Other _____

Suite 201, 9711-45th Avenue Edmonton Alberta T6E 5V8
T: 780-434-7666 F: 780-436-4165 Toll Free: 1-877-234-7666 E: crpna@crpna.ab.ca

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Provide the following information to support this recommendation. Please attach additional pages, supporting letters and/or reports as necessary. For accommodation requests based on a learning disability, a copy of the most recent Psycho-educational Assessment must be included with this form.

Approximate date the disability was first diagnosed and/or identified: _____.

A brief history and description of the disability including the functional limitations which prevent the candidate from writing the exam in the usual method and/or environment:

_____

_____

A description of the current treatment plan and why this is not effective in overcoming the functional limitations of the disability, thereby necessitating the above accommodations:

_____

_____

Health Professional Name	Email	Phone Number
Title	Signature	Date

Hint: Use 'Fill & Sign' feature Then select ' Add Signature' from menu

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